

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

**APPLICATION FOR CERTIFICATION TO PROVIDE LIMITED SERVICES
TO AN INDIVIDUAL UNDER THE SELF-ADMINISTERED SERVICES**

Name of Applicant: _____

Date: _____

Address: _____

Phone: _____

Name of Person Applicant Desires to Support: _____

Service(s) Applicant Desires to Provide (*Circle All Applicable Services*): **PA1 (Q);**.

Knowledge Requirements for Certification:

Employment Agreement ☐ Date _____

Department of Human Services
Provider Code of Conduct ☐ Date _____

Division of Services for People With
Disabilities' (Division) Code of Conduct ☐ Date _____

First Aid Training ☐ Date _____

SIGNATURES:

I represent that I have read and am familiar with the above-identified materials and that I have been oriented to and/or trained on all of the materials by: _____ on the dates indicated. I further represent that I both understand and will comply with the requirements identified in the materials in providing services to the Person and that I am capable of providing appropriate services to the Person.

Signature of Applicant

Date

I, _____ represent that I am the Person, the Person's Representative, or the Person with a Designated Administrator of Supports for the Person and that I am familiar with both the above-identified materials and the supports required by the Person. I further represent that I provided orientation and/or training to the Applicant on all of the required materials on the dates indicated. I further represent that based on the training and orientation provided to the Applicant, I am satisfied the Applicant has the knowledge, understanding, and ability to provide appropriate services to the Person.

Signature of Person, Guardian, or Designated Administrator

Date